YOUTH SERVICES
OFFICE OF JUVENILE JUSTICE
PRE- EMPLOYMENT HEALTH HISTORY QUESTIONNAIRE

1. ____ YES ____ NO Are you currently under the care of a physician/ health care provider?
   If YES, please answer the following:
   Physician/HCP treating you: _____
   Diagnosis: _____

2. Circle each item that you have had a problem with in the past (meaning since birth to present):

A. MUSCLES, BONES, AND JOINTS (Pain, sprain, fracture, dislocation, surgery):
Neck Upper back Mid back Lower back Hip Knee Ankle Foot
Shoulder Elbow Wrist Hand Fingers Arthritis Gout
Provider comments: _____

B. SKIN: Itching Rash Hives Eczema
Provider comments: _____

C. CHEST AND LUNGS: Asthma Shortness of Breath
Provider comments: _____

D. NEUROLOGICAL: Seizures/Epilepsy Fainting Blackouts Muscle weakness Paralysis Numbness Tingling in hands, feet or face
Provider comments: _____

E. HEART: Heart problems? High Blood Pressure
Provider comments: _____

F. ENDOCRINE: Diabetes Thyroid problems Any other endocrine problems?
Provider comments: _____

G. GASTROINTESINAL (GI): Any history of stomach/ other GI problems? Hepatitis Hernia
Provider comments: _____

H. MENTAL HEALTH: Any uncontrolled anxiety/depression/other problems?
Provider comments: _____

I. INFECTIONS: Herpes infection of the finger? Cold sores Tuberculosis Hepatitis A B C (circle all)
Provider comments: _____

3. ____ YES ____ NO Do you have problems with latex gloves/other rubber products?
   If YES, please identify the product: _____
4. ____ YES ____ NO Are there any other health conditions that you would like us to know about?
   If YES, please explain: _____
5. ____ YES ____ NO Have you had the Chicken Pox/ Varicella?
6. ____ YES ____ NO Have you had the Measles?
7. ____ YES ____ NO Have you had the Mumps?
8. ____ YES ____ NO Have you had Rubella (3-day Measles)?
9. List Prescription Medications, Herbal Drugs and Over the Counter Medications that you are currently taking?

_____
_____
_____

10. List Allergies you have to food, drugs, pollens, chemicals, latex, etc:

_____
_____

11. ____ YES ____ NO A. Have you ever been hospitalized?
    Explain: _____

YES NO B. Have you ever had surgery?

List year and type: _____

_____

_____

YES NO C. Do you have persistent (**circle**) upper back pain, mid-back pain, low back pain, neck pain, or arm pain?

If yes:

Do you now have pain: **Rarely** **Occasionally** **Frequently**

- What is the longest period of time this bothered you?
- When was the last time you sought medical evaluation?
- ___Yes ___ No Do you have any numbness/tingling/weakness in your arms or legs? If yes, Where: _____
- ___Yes ___ No Have you had surgery or seen a surgeon for this problem?

IMMUNIZATIONS:

Please respond Yes, No, or NS (Not Sure)

1. ____ YES ____ NO ____ NS Tetanus Year: _____
2. ____ YES ____ NO ____ NS Hepatitis B Year: _____ If yes, titer; Year: _____ Results: _____
3. ____ YES ____ NO ____ NS Hepatitis A Year: _____
4. ____ YES ____ NO ____ NS MMR Year: _____ If yes, Rubella titer; Results: _____
5. ____ YES ____ NO ____ NS Varicella (Chicken Pox) Year: _____

PERSONAL HEALTH HABITS HISTORY:

1. ____ YES ____ NO Have you ever smoked?

   ____ YES ____ NO Are you a current smoker? If No, when did you quit? _____

   _____

2. ____ YES ____ NO Do you drink alcohol? How much do you drink each week?
3. ____ YES ____ NO Have you ever been treated for chemical (illegal or legal drugs or alcohol) dependency?

   Explain: _____

PAST WORK HISTORY:

1. Give your immediate past job title (Custodian, Administrative Assistant, Physician, etc)

   Length of time in this position: _____ Years _____ Months
2. ____ YES ____ NO Have you ever been injured on the job in any way? If yes, explain: _____

   _____
3. ____ YES ____ NO Have you ever received Workers Compensation benefits?

   If yes, please answer the following:

   - Name of employer at the time of injury? _____
   - Type of injury: _____
   - Date of injury: _____
   - Job title at time of injury: _____
   - How long were you off work: _____
4. ____ YES ____ NO Have you ever had to transfer from one job to another, or changed work duties because of health problems?

   Explain: _____
5. ____ YES ____ NO Have you ever been refused any job for health problems?

   Explain: _____
6. ____ YES ____ NO Has a doctor ever placed restrictions on the kind of work or activities you should do?

   Explain: _____
7. ____ YES ____ NO Have you ever received an impairment rating or a disability rating?

   Explain: _____

Applicant's Signature: _____ Date: _____

Provider Signature: _____ Date: _____